General Assembly **Substitute Bill No. 861**

January Session, 2013

* SB00861INS 022713 *

AN ACT CONCERNING THE MODERNIZATION OF CERTAIN MEDICAL FORMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) (1) Each health carrier shall contract with (A) health care professionals to administer such health carrier's utilization review program and oversee utilization review determinations, and (B) with clinical peers to evaluate the clinical appropriateness of an adverse determination.

(2) Each utilization review program shall use current, documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 38a-591b to assure such program's ongoing effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner. Each health carrier shall make its clinical review criteria available electronically to health care professionals with whom such carrier has contracted to provide health care services to its covered persons and upon request to authorized government agencies.

(b) Each health carrier shall:

(1) Have procedures in place to ensure that the health care professionals administering such health carrier's utilization review program are applying the clinical review criteria consistently in utilization review determinations;

(2) Have data systems sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(3) Provide covered persons and participating providers with access to its utilization review staff through a toll-free telephone number or any other free calling option or by electronic means;

(4) Coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, processes for assessing member satisfaction and risk management; and

(5) Routinely assess the effectiveness and efficiency of its utilization review program.

(c) If a health carrier delegates any utilization review activities to a utilization review company, the health carrier shall maintain adequate oversight, which shall include (1) a written description of the utilization review company's activities and responsibilities, including such company's reporting requirements, (2) evidence of the health carrier's formal approval of the utilization review company program, and (3) a process by which the health carrier shall evaluate the utilization review company's performance.

(d) When conducting utilization review, the health carrier shall (1) collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination, and (2) ensure that such review is conducted in a manner to ensure the

independence and impartiality of the individual or individuals involved in making the utilization review or benefit determination. No health carrier shall make decisions regarding the hiring, compensation, termination, promotion or other similar matters of such individual or individuals based on the likelihood that the individual or individuals will support the denial of benefits.

(e) (1) Not later than January 1, 2014, the commissioner shall develop uniform prior authorization forms for health care services, including, but not limited to, health care professional office visits, prescription drug benefits, and imaging and other diagnostic or laboratory testing. The commissioner shall seek input from health carriers, utilization review companies, health care professionals and other stakeholders for the development of such forms. The commissioner may develop different forms for different health care services as the commissioner deems necessary or appropriate.

(2) Any such forms shall (A) not exceed two pages, (B) be available in paper format and electronic format, (C) be capable of being completed and submitted electronically, and (D) be consistent with existing prior authorization forms established by the Centers for Medicare and Medicaid Services and with any national standards pertaining to electronic prior authorization procedures.

(3) Upon developing such forms, the commissioner shall notify health carriers of the availability of such forms. Each health carrier shall notify and make such forms available to utilization review companies to which such carrier has delegated any utilization review activities and to health care professionals with whom such carrier has contracted to provide health care services to its covered persons. Not later than one hundred eighty days after the commissioner provides such notification, each such health care professional shall use, and each health carrier or utilization review company that requires prior authorization for a health care service shall use and accept, such forms. If such carrier or company fails to accept a prior authorization form developed pursuant to this subsection, for which all required

information is submitted, or such carrier or company fails to grant or deny such prior authorization within twenty-four hours of such carrier or company's receipt of such prior authorization request, such prior authorization shall be deemed granted.

(4) Nothing in this subsection shall prohibit a health carrier or utilization review company from using, in lieu of paper format, a prior authorization system that utilizes an Internet web site, an Internet-based portal or other electronic systems to access or submit a prior authorization form developed pursuant to this subsection.

Sec. 2. Section 38a-478e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Each managed care organization shall, prior to implementing new medical protocols or substantially or materially altering existing medical protocols, obtain input from physicians actively practicing in Connecticut and practicing in the relevant specialty areas. The managed care organization shall also seek input from physicians who are not employees of or consultants, other than to the extent a person is an employee or consultant solely for the purposes of this subsection, to the managed care organization provided the input is not unreasonably withheld. The managed care organization shall obtain the input in a manner permitting verification by the commissioner and shall document the process by which it obtained the input. For the purpose of this section, "medical protocols" shall include, but not be limited to, drug formularies or lists of covered drugs and clinical criteria used for utilization review, as defined in section 38a-591a.

(b) Each managed care organization shall (1) make available **[**, upon the request of a**]** to its participating **[**provider**]** providers on such organization's Internet web site, its current medical protocols, **[**for examination during regular business hours at the principal Connecticut headquarters of the managed care organization,**]** and (2) if a managed care organization denies a treatment, service or procedure, the organization shall furnish, upon the request of a participating

provider, a copy of the relevant medical protocol to the participating provider, along with an explanation of the denial at the time the denial is made.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2013*	38a-591c
Sec. 2	*October 1, 2013*	38a-478e

INS *Joint Favorable Subst.*